

# Medicare Crossovers

# Medicare Crossovers

- Claims crossover automatic from COBC-GHI
- What does crossover
  - Institutional Claims
  - Professional Claims
- What doesn't crossover (exempt)
  - Part C
  - Hospice
  - Non-assigned Medicare claims
  - Adjustments from Medicare
  - NCPDP Claims

## Claims that do not crossover

- Options
  - Bill electronically with appropriate Medicare qualifiers and data included in transaction
  - Bill electronically with PWK indicator and send Medicare EOB as paperwork attachment
  - Bill on Paper Forms

# Billing Medicare Electronically

- Medicare Paid Amount:
  - Loop 2430 Segment SVD Data Element 02  
(Line Level)
- Medicare Co-insurance:
  - Loop 2430 Segment CAS Data Element 02 Reason= 2
- Medicare Deductible:
  - Loop 2430 Segment CAS Data Element 02 Reason= 1

# **Medicare Secondary**

## **Using WINASAP2003**

- Indicate Medicaid as Secondary in patient file
- Enter Medicare information under other subscribers information
- Indicate paperwork attachment if Medicare denies
- Send in EOB and Reason & Remark Codes

Patient List

Patient ID #	Patient Account No	Patient SSN	Patient Name	Sex	Date of Birth	Patient Telephone #
--------------	--------------------	-------------	--------------	-----	---------------	---------------------

# Medicare

## Billed Electronically in WINASAP3002

Patient Data

Patient Data
Insured's Data

Insured's Information

Patient ID #:

Insured's SSN:

Patient Relationship to Insured:

Insured's Primary ID:

Entity Type:

Insured's Group or Plan Name:

Organization Name:

Insured's Group or Policy #:

Last Name:

Insured's Address:

First Name:

Insured's Address (cont):

Middle Name/Initial:

Insured's City:

Suffix:

Insured's State:

Insured's Zip Code:

Date of Birth:

Sex:

Payer Information

Payer Name:
MONTANA DPHHS

Payer Address:

Address (cont):

City:

State:

Zip:

Payer Primary ID:
77039

Payer Secondary ID:

Payer Responsibility Sequence Code:
Secondary

Patient Data

Save

Listing 0 of 0

## Professional Claim Data

Claim Data Claim Codes Claim Information Claim Line Items

Claim Information

Additional Claim Level Information

Miscellaneous Dates	Supplemental Info
Contract Info	Ambulance Transport Info
Spinal Manipulation Info	Vision Info
EPSDT Info	Home Health Info
Service Facility Info	Claim Note
Other Subscriber Info	Related Causes Info
File Info	

Next Page

Previous Page

Save

Cancel

Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Additional Claim Level Information

Miscellaneous

Content

Spinal Manipulation

EPS

Service

Other Services

Other Subscriber Information

Other Subscriber Page 1 | Other Subscriber Page 2

1

Insured's Name

Patient Relationship To Insured:

Self

Entity Type: Person

Organization Name:

Last Name: Data

First Name: Test

Middle Name/Initial:

Suffix:

Date of Birth: 08/09/1944

Sex:

☒ Male

☐ Female

☐ Unknown

Insured's Address

Address: 101 Main Drive

Address (con't):

City: Somewhere

State: MT

Zip Code: 59999-0000

Country: United States

Insured's Identification

Insured's Primary ID Type: Member Identification Number

Secondary Identification

Insured's Primary ID: 111001111A

Delete

First

Previous

Next

Last

OK

Cancel



## Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Additional Claim Level Information

Miscellaneous

Contact

Spinal Mal

EPS

Service

Other Su

## Other Subscriber Information

Other Subscriber Page 1 | Other Subscriber Page 2

1

## Insurance Information

Group or Policy #:  Group or Plan Name: 

Insurance Type Code: Medicare Part B Claim Filing Indicator: Medicare Part B

Release of Information Code: Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organiz:

Patient Signature Source Code: Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on

Assignment of Benefits Indicator: ☐ Yes

COB Amounts

Outpatient Adjudication Info

## Other Payer Information

Payer Name: Test Data Payer Responsibility Sequence Code: Primary

Payer Primary ID Type: Payor Identification Payer Primary ID: 111001111A

Payer Address:  Payer Address (con't): Payer City:  Payer State:  Payer Code:  Payer Country: 

Claim Adjudication Date: 08/08/2011

Claim Adjustment Indicator: ☐ Yes

Patient Information

Service Facility ID

Secondary ID Information

Adjustment Info

Rendering Provider ID

Supervising Provider ID

Purch Service Provider ID

Prior Auth/ Referral Number

Referring Provider ID

Delete

First

Previous

Next

Last

OK

Cancel



Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Additional Claim Level Information

Miscellaneous Dates	Supplemental Info
Contract Info	Ambulance Transport Info
Spinal Manipulation Info	
EPSDT Info	
Service Facility Info	
Other Subscriber Info	Related Claims
File Info	

Next Page Previous Page Save Cancel

Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Addition

**Supplemental Information**

	Report Code	Transmission Code	Identification Code
1:	Explanation of Benefits	By Fax	111001111-1234567890-05042011
2:			
3:			
4:			
5:			
6:			
7:			
8:			
9:			
10:			

Delete Data

OK Cancel

Cancel



## Paper Billing

- Institutional
  - Use form locators 39-41 for co-insurance and/or deductible
  - Paid amount in form locator 54
    - No EOB required for Paid Claims
  - Denials must have Medicare EOB with reason and remark codes description of reason and remark codes attached

Medicaid Only  
**Required Fields are Highlighted**

[illegible]

151 Columns

Fill Colors:

	Required Fields
	Conditional Fields
	Other

### Border Colors

Border Colors

-  Client Fields
-  Provider Fields
-  Billing Fields

NUBC<sup>®</sup> 800-874-7623  
www.nubc.com UC6018257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

# Medicare Coinsurance and Deductible

## Medicaid Only Required Fields are Highlighted

Take Time Medical Center 104 Time Square Helena, MT 59601-0104		4806 Grisw97531 02/01/11 02/01/11 9912345	
PATIENT NAME: 111001111		PATIENT ADDRESS: 1313 Mockingbird Lane, Metropolis, MT 59601-1313	
BIRTHDATE: 03/26/30 SEX: M DATE: 02/01/11 TIME: 11:01		ADDITIONAL CODES: A1 66.00 A2 15.00	
GRISWOLD, CLARK 1313 Mockingbird Lane Metropolis, MT 59601-1313			
450 ER	90760	4	3200.00
636 Other Pharmacy N4 00409909332 UN 5	J3010	1	620.00
270 General Class Medical/Surgical Supplies		110	583.00
300 General Class Laboratory	81001	4	500.00
PAGE 01 OF 01		CREATION DATE: 04/01/11	TOTALS: 4903.00
HEALTH PLAN NAME: Medicaid		EST. AMOUNT DUE: 1876543210	
INSURED'S NAME: Griswold, Clark		INSURANCE GROUPING: 111001111	
TREATMENT AUTHORIZATION CODES: 10987645321		DOCUMENT CONTROL NUMBER: 780.39	
OTHER PROCEDURE CODES: 540.0		OTHER PROCEDURE CODES: 1766554433	
OTHER PROCEDURE CODES: 1253456789		OTHER PROCEDURE CODES: 3631P0000X	
OTHER PROCEDURE CODES: 3631P0222X		OTHER PROCEDURE CODES: 3631P0000X	

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THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE VALID FOR ONE YEAR.

### Fill Colors:

- Required Fields
- Conditional Fields
- Other

### Border Colors:

- Client Fields
- Provider Fields
- Billing Fields

## Paper Billing

- Bill on paper claim forms
  - Professional
    - Do not enter Medicare information on 1500
      - No Medicare paid amount in field 29
    - Attach a copy of the Medicare EOB for all paper claims submitted
      - Include reason and remark code description for all Medicare denials

# TPL

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05

### Medicaid Only Coverage

Fill Colors:

- Required Fields
- Conditional Fields
- Other

Border Colors

- Client Fields
- Provider Fields
- Billing Fields

<input type="checkbox"/> PIGA		<input type="checkbox"/> PIGA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FFDA OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)		3. INSURED'S I.D. NUMBER (For programs not 15)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Flintstone, Fred T</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) <b>112 Rocky Rd.</b>		7. INSURED'S ADDRESS (No., Street)	
CITY <b>Bedrock</b> STATE <b>BC</b>		CITY STATE	
ZIP CODE <b>54321-1234</b> TELEPHONE (Include Area Code) <b>(406) 765-4321</b>		ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F		b. AUTO ACCIDENT?	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT?	
d. INSURANCE PLAN NAME OR PROGRAM NAME		101. RESERVED FOR LOCAL USE <b>123456789</b>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURANCE POLICY OR GROUP IDENTIFICATION NUMBER	
SIGNED _____ DATE _____		SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or Pregnancy/LMP) MM DD YY <b>01 01 09</b>		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>Great Gazoo MD</b>		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		20. OUTSIDE LAB? YES NO \$ CHARGES	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE D. PROVIDER'S OR SUPPLIER'S E. DIAGNOSIS F. CHARGES G. DEDUCTIBLE H. CO-INSURANCE I. J. REFERRING PROVIDER ID #		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input checked="" type="checkbox"/> BV12345		23. FIM OR AUTHORIZATION NUMBER	
26. PATIENT'S ACCOUNT NO. BV12345		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE D. PROVIDER'S OR SUPPLIER'S E. DIAGNOSIS F. CHARGES G. DEDUCTIBLE H. CO-INSURANCE I. J. REFERRING PROVIDER ID #	
27. ACCEPT ASSIGNMENT? (For grant, assign, own back) YES NO		25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input checked="" type="checkbox"/> BV12345	
28. SERVICE FACILITY LOCATION INFORMATION		26. PATIENT'S ACCOUNT NO. BV12345	
29. TOTAL CHARGE \$ 100.00		27. ACCEPT ASSIGNMENT? (For grant, assign, own back) YES NO	
30. AMOUNT PAID \$ 85.00		28. SERVICE FACILITY LOCATION INFORMATION	
31. BALANCE DUE \$ 100.00		29. TOTAL CHARGE \$ 100.00	
32. BILLING PROVIDER INFO & PII # Yabba-Dabba Center 2121 Granite Slab Dr. Bedrock, BC 54321-1234		30. AMOUNT PAID \$ 85.00	
33. BILLING PROVIDER INFO & PII # 1876543215		31. BALANCE DUE \$ 100.00	
34. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials. I certify that the statements on the reverse apply to this bill and are made as a partner/agent)		32. BILLING PROVIDER INFO & PII # 1876543215	
Rocky Shalstone, MD 01/01/11		33. BILLING PROVIDER INFO & PII # 1876543215	
SIGNED _____ DATE _____		34. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials. I certify that the statements on the reverse apply to this bill and are made as a partner/agent)	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-093

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# Medicare

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05

### Medicaid Only Coverage

Fill Colors:

- Required Fields
- Conditional Fields
- Other

Border Colors

- Client Fields
- Provider Fields
- Billing Fields

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (Tricare #) <input type="checkbox"/> CHAMPVA (Champion's SSN) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA (FECA #) <input type="checkbox"/> OTHER (Other #) <input type="checkbox"/>		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Plintstone, Fred T</b>		3. PATIENT'S BIRTH DATE MM DD YY <b>08 30 1960</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
6. PATIENT'S ADDRESS (No., Street) <b>112 Rocky Rd.</b>		7. INSURED'S ADDRESS (No., Street)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		9. INSURED'S STATUS (No., Street)	
CITY <b>Bedrock</b>		STATE <b>BC</b>		CITY		STATE	
ZIP CODE <b>54321-1234</b>		TELEPHONE (Include Area Code) <b>(406) 765-4321</b>		ZIP CODE		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY NUMBER OR FECA NUMBER		12. INSURED'S DATE OF BIRTH MM DD YY <b>MM DD YY</b>	
13. OTHER INSURED'S POLICY OR GROUP NUMBER		14. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		15. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		16. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
17. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		18. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		19. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		20. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
21. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		22. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		23. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		24. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
25. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		26. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		27. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		28. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
29. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		30. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		31. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		32. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
33. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		34. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		35. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		36. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
37. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		38. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		39. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		40. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
41. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		42. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		43. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		44. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
45. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		46. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		47. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		48. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
49. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		50. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		51. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		52. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
53. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		54. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		55. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		56. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
57. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		58. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		59. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		60. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
61. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		62. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		63. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		64. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
65. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		66. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		67. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		68. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
69. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		70. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		71. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		72. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
73. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		74. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		75. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		76. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
77. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		78. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		79. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		80. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
81. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		82. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		83. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		84. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
85. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		86. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		87. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		88. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
89. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		90. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		91. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		92. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
93. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		94. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		95. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		96. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	
97. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		98. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		99. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		100. INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	

## Part C Medicare HMO Plans

- Currently processed as Medicare Part B claims
  - Copay amounts entered as deductible
  - Coinsurance entered as coinsurance
  - Deductible entered as deductible
  - Deductible + Co-ins + Copay entered as deductible
- Claims processing system cannot process Medicare correctly without a Medicare paid amount if a co-insurance is present
  - Medicare paid and deductible/co-insurance all considered in pricing formula

# Common Issues Resulting in Denials

- Client has Medicare on file and no Medicare information is present on claim
- Medicare denied service as not medically necessary
- Medicare EOB and claim do not match
  - Check
    - Client, date of service, billed amount, and procedure code
- Medicare denial reasons are not attached

# Common Issues Resulting in Denials

- Medicare denied as a duplicate
- Medicare denied for a billing error
- Medicare denied for timely filing
- Medicare denied for service not paid separately
- Medicare denied because service paid by another payer

# Third Party Liability

## **TPL Responsibilities**

- Insurance verification
- Assist with problem claims
- Retro Medicare
- Carrier Billing
- Provider checks/refunds
- Credit balance
- Trauma investigations

## Services to you

- Pay and Chase
  - 90 Day Rule- Providers can request that Montana's Healthcare Programs process the claim and subsequently bill the other payer.
  - Specific circumstances result in automatic pay and chase.
    - Some prenatal and pediatric codes

# Billing TPL Electronically

- TPL Information
  - Loop 2320 Segment SBR Data Element 09
- TPL Payment
  - Loop 2320 Segment AMT Data Element 02

## **Billing TPL in WINASAP2003**

- Indicate Medicaid as Secondary in patient file
- Enter other subscriber information
- Submit by direct submission or uploading

Patient List

Patient ID #	Patient Account No	Patient SSN	Patient Name	Sex	Date of Birth	Patient Telephone #
--------------	--------------------	-------------	--------------	-----	---------------	---------------------

# TPL

## Billed Electronically in WINASAP3002

Patient Data

Patient Data
Insured's Data

Insured's Information

Patient ID #:

Insured's SSN:

Patient Relationship to Insured:

Insured's Primary ID:

Entity Type:

Insured's Group or Plan Name:

Organization Name:

Insured's Group or Policy #:

Last Name:

Insured's Address:

First Name:

Insured's Address (cont):

Middle Name/Initial:

Insured's City:

Suffix:

Insured's State:

Insured's Zip Code:

Date of Birth:

Sex:

Payer Information

Payer Name:
MONTANA DPHHS

Payer Address:

Address (cont):

City:

State:

Zip:

Payer Primary ID:
77039

Payer Secondary ID:

Payer Responsibility Sequence Code:
Secondary

Patient Data

Save

Professional Claim Data

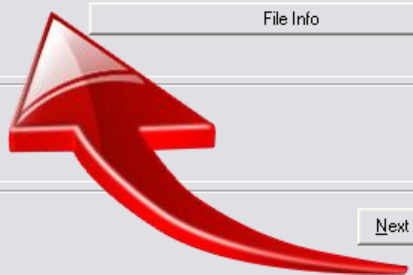
Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Additional Claim Level Information

Miscellaneous Dates	Supplemental Info
Contract Info	Ambulance Transport Info
Spinal Manipulation Info	Vision Info
EPSDT Info	Home Health Info
Service Facility Info	Claim Note
Other Subscriber Info	Related Causes Info

File Info



Next Page Previous Page Save Cancel

Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Additional Claim Level Information

Miscellaneous

Contract

Spinal Mal

EPS

Service

Other Su

Other Subscriber Information

Other Subscriber Page 1 | Other Subscriber Page 2

1

Insured's Name

Patient Relationship To Insured:

Self

Entity Type:

Person

Organization Name:

Last Name:

Data

First Name:

Test

Middle Name/Initial:

Suffix:

Date of Birth:

08/09/1944

Sex:

☒ Male

☐ Female

☐ Unknown

Insured's Address

Address:

100 Main Street

Address (con't):

City:

Somewhere

State:

MT

Zip Code:

59999-0000

Country:

United States

Insured's Identification

Insured's Primary ID Type:

Member Identification Number

Insured's Primary ID:

111001111

Secondary Identification

Delete

First

Previous

Next

Last

OK

Cancel



Professional Claim Data

Claim Data Claim Codes Claim Information Claim Line Items

Claim Information

Additional Claim Level Information

Miscellaneous

Contract

Spinal Manipulation

EPS

Service

Other Subscriber

Other Subscriber Information

Other Subscriber Page 1 Other Subscriber Page 2

1

Insurance Information

Group or Policy #: BBB12345

Group or Plan Name: That Insurance Co

Insurance Type Code: Commercial

Claim Filing Indicator: Commercial Insurance Company

Release of Information Code: Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization

Patient Signature Source Code: Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file

Assignment of Benefits Indicator: ☐ Yes

COB Amounts

Outpatient Adjudication Info

Other Payer Information

Payer Name: Test Data

Responsibility Sequence Code: Primary

Payer Primary ID Type: Payor Identification

Payer Primary ID: 111001111

Payer Address:

Payer Address (cont):

Payer City:

Payer State:

Payer Code:

Payer Country:

Claim Adjudication Date: 08/16/2011

Claim Adjudication Indicator: ☐ Yes

Patient Information

Service Facility ID

Secondary ID Information

Adjustment Info

Rendering Provider ID

Supervising Provider ID

Purch Service Provider ID

Prior Auth/ Referral Number

Referring Provider ID

Delete

First

Previous

Next

Last

OK

Cancel

Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Additional Claim Level Information

Miscellaneous

Contract

Spinal Manipulation

EPS

Service

Other Services

Other Subscriber Information

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1

Insurance Information

Group or Policy

Insurance Type

Release of Information

Patient Signature Source

Assignment of Benefits

Other Payer Information

Payer Name

Payer Primary ID Type

Payer Address

Payer City

Claim Adjudication Date

COB Information

Paid Amount: 52.00

Discount Amount:

Approved Amount:

Per Day Limit Amount:

Allowed Amount:

Patient Paid Amount:

Responsible Amount:

Tax Amount:

Covered Amount:

Pre-Tax Claim Total Amount:

Delete Data

OK

Cancel

Patient Information

Service Facility ID

Secondary ID Information

Adjustment Info

Rendering Provider ID

Supervising Provider ID

Purch Service Provider ID

Priority Referral Number

Referring Provider ID

First

Previous

Next

Last

OK

Cancel

## Blanket denial

- Include documentation that the client's other insurance never pays for a particular service.
- Requests are available on the web or from TPL. Complete and return requests to TPL.  
Fax to 406-442-0357.
- In return you will receive the blanket denial along with a tracking reference number to be used for billing.

**REQUEST FOR BLANKET DENIAL LETTER  
ACS - State of Montana Medicaid**

**Effective Date Requested** \_\_\_\_\_ **Provider / NPI #** \_\_\_\_\_

**Client Name** \_\_\_\_\_

**Medicaid ID #** \_\_\_\_\_

**Name of Insurance Company on File:** \_\_\_\_\_

**Procedure Codes Requested:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Requesting Agency** \_\_\_\_\_

**Fax Number** \_\_\_\_\_

**Contact Person** \_\_\_\_\_

**Contact Phone Number** \_\_\_\_\_

**Number of Pages That Follow Request** \_\_\_\_\_

**PLEASE FAX ALL REQUESTS TO (406) 442-0357.**

Request must include an EOB stating the services are not covered.

## How to bill using a blanket denial

- ACS staff work TPL edits that post for which a blanket denial has been created.
  - Electronic claims: include *pwk* indicator and tracking number.
  - Paper Claims: send the claim and a copy of the blanket denial
- Blanket denials are valid for two years from date on the request. Renewals must be requested and are not automatic.

Claim Information

**Supplemental Information**

	Report Code	Transmission Code	Identification Code
1:	Explanation of Benefits	By Fax	TPL111001111024
2:			
3:			
4:			
5:			
6:			
7:			
8:			
9:			
10:			

Delete Data

OK Cancel

**Blanket Denial**



## Common Problems

- No TPL amount on the claim
  - If you have information TPL has termed please call provider relations @ 1-800-624-3958
- Medicare information is put in as a TPL amount
- No paperwork attachments

Phone Number  
Read as TPL

1500										Medicaid Only Coverage										FICA									
HEALTH INSURANCE CLAIM FORM										Fill Colors:										Border Colors									
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05										<input type="checkbox"/> Required Fields <input type="checkbox"/> Conditional Fields <input type="checkbox"/> Other										<input type="checkbox"/> Client Fields <input type="checkbox"/> Provider Fields <input type="checkbox"/> Billing Fields									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> IDICAGE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>										2. INSURED'S ID NUMBER										3. INSURED'S NAME (Last Name, First Name, Middle Initial)									
4. PATIENT'S NAME (Last Name, First Name, Middle Initial) Flintstone, Fred T										5. PATIENT'S BIRTH DATE 08/30/1960										6. INSURED'S NAME (Last Name, First Name, Middle Initial)									
7. PATIENT'S ADDRESS (No., Street) 112 Rocky Rd.										8. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										9. INSURED'S ADDRESS (No., Street)									
10. PATIENT'S CITY Bedrock										11. PATIENT'S STATE BC										12. INSURED'S CITY									
13. PATIENT'S ZIP CODE 54321-1234										14. PATIENT'S TELEPHONE (Include Area Code) (406) 765-4321										15. INSURED'S ZIP CODE									
16. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										17. IS PATIENT'S CONDITION RELATED TO:										18. INSURED'S DATE OF BIRTH									
19. OTHER INSURED'S POLICY OR GROUP NUMBER										20. EMPLOYMENT? (Current or Previous)										21. INSURED'S DATE OF BIRTH									
22. OTHER INSURED'S DATE OF BIRTH										23. AUTO ACCIDENT?										24. EMPLOYER'S NAME OR SCHOOL NAME									
25. EMPLOYER'S NAME OR SCHOOL NAME										26. OTHER ACCIDENT?										27. INSURANCE PLAN NAME OR PROGRAM NAME									
28. INSURANCE PLAN NAME OR PROGRAM NAME										29. RESERVED FOR LOCAL USE 123456789										30. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
31. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										32. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										33. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE									
34. SIGNED										35. DATE										36. SIGNED									
37. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or Pre-Existing Injury)										38. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE										39. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
40. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo MD										41. ID 9954321										42. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
43. RESERVED FOR LOCAL USE										44. 1324675908										45. OUTSIDE LAB?									
46. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										47. 780, 60										48. MEDICAID RESUBMISSION CODE									
49. 2										50. 2										51. 23									
52. A. DATE(S) OF SERVICE										53. B. C. D. E. F. G. H. I. J.										54. 36LP00000X									
55. 01/01/09										56. 01/01/09										57. 1213456789									
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# Medicaid Entered as other insurance

**1500**  
**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

**Medicaid Only Coverage**  
Fill Colors:  
☒ Required Fields  
☒ Conditional Fields  
☐ Other

Border Colors  
☒ Client Fields  
☐ Provider Fields  
☐ Billing Fields

PIC# ☐ ☐ ☐ ☐

1. MEDICARE ☐ MEDICAID ☒ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FFCA ☐ OTHER ☐  
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
**Flintstone, Fred T**

3. PATIENT'S BIRTH DATE  
MM DD YY **08 30 1960** SEX ☒ M ☐ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)  
**112 Rocky Rd.**

6. PATIENT RELATIONSHIP TO INSURED  
Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS  
Single ☐ Married ☒ Other ☐

9. CITY **Bedrock** STATE **BC**

10. ZIP CODE **54321-1234** TELEPHONE (Include Area Code)  
**(406) 765-4321**

11. EMPLOYER'S NAME OR SCHOOL NAME

12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

13. IS PATIENT'S CONDITION RELATED TO:  
a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO  
b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) ☐ ☐  
c. OTHER ACCIDENT? ☐ YES ☒ NO

14. INSURED'S DATE OF BIRTH  
MM DD YY ☐ M ☐ M ☐ F

15. EMPLOYER'S NAME OR SCHOOL NAME

16. INSURANCE PLAN NAME OR PROGRAM NAME  
**Medicaid**

17. IS THERE ANOTHER HEALTH BENEFIT PLAN?  
☒ NO ☐ YES If yes, return to and complete item 9 and 10.

18. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

19. DATE OF CURRENT ILLNESS (First symptom or INJURY (accident or trauma))  
MM DD YY **01 01 09**

20. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE  
MM DD YY

21. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
**Great Gazoo MD**

22. ID: **9954321**  
NPI: **1324675908**

23. HOSPITALIZATION DATE  
FROM MM DD TO MM DD YY

24. OUTSIDE LAB? ☐ YES ☒ NO

25. MEDICAID RESUBMISSION CODE ORIGINAL REF NO.

26. PRIOR AUTHORIZATION NUMBER

27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)  
**780 .60**

28. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. PROCEDURE (Explain Use of Diagnostic) D. SERVICES OR SUPPLIES (List CPT/HCPCS) E. DIAGNOSIS (ICD-9-CM) F. CHARGES G. DEDUCTIBLE H. COINSURANCE I. PREPAYMENT J. RENDERING PROVIDER ID #

1 01 01 11 01 01 11 11 0 99231 1 100 00 1 6 ZZ 36LP00000X  
NPI 1213456789

25. FEDERAL TAX I.D. NUMBER **99-9999999** SSN EIN ☒ ☐ 26. PATIENT'S ACCOUNT NO. **BV12345** 27. ACCEPT ASSIGNMENT? ☒ YES ☐ NO 28. TOTAL CHARGE \$ **100.00** 29. AMOUNT PAID \$ 30. BALANCE DUE \$ **100.00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statements on the reverse apply to this bill and are made a partnership.)  
**Rory Flintstone MD** 01/01/11  
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION  
a. NPI b.

33. BILLING PROVIDER INFO & PII # **(406) 555-1234**  
**Yabba-Dabba Center**  
**2121 Granite Slab Dr.**  
**Bedrock, BC 54321-1234**  
a. **1876543215** b. **ZZ 400RT0010X**

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

## **What should I send to TPL?**

- Problem TPL claims
- 90 day pay and chase claims
- Verification requests from TPL
- Blanket denials
- Refund checks
  - Note if it's for credit balance

## Contact Information

Danielle Brenimer – TPL supervisor

Phone 406-457-9530

Email: [daniel.brenimer@acs-inc.com](mailto:daniel.brenimer@acs-inc.com)

Denise Juvik – PR Field Representative

Phone 406-457-9598

Email: [denise.juvik@acs-inc.com](mailto:denise.juvik@acs-inc.com)

# Questions

